NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
2010 MEDICAID SERVICES AUDIT

PROVIDER NAME:	**AUDIT DATE:**
PROVIDER #:	**NAME:**
CONTROL #:	**SERVICE TYPE:**
MEDICAID #:	**PROCEDURE CODE:**
DOB/AGE:	**SERVICE DATE:**
RECORD #:	**UNITS PAID:**

RATING CODES:	**O = No** **2 = partially met** **4 = Yes**	**6 = No service note** **7 = Unable to identify service provider**	**8 = Repaid** **9 = NA**	**RATING**

AUTHORIZATIONS/PERSON CENTERTED PLAN (Use rating of "4" or "0" for Q 1-3		
1. a. Is an authorization in place covering this date of service? **b. If NO, list dates: FROM_____TO_____**		
2. a. Is there a valid service order for the service billed? **b. If NO, list dates: FROM_____ TO_____**		
3. a. Is the date of service covered by a valid PCP? **b. If NO, list dates: FROM_____TO_____**		
SERVICE DOCUMENTATION (Use Likert Scale See Instructions): **(Use rating of "4", "2" or "0" for Q 4-9 and "4" or "0" for Q10—or ratings of 6, 8, or 9 as applicable)**		
4. a. Is the PCP individualized per person? **b. If NO, list dates: FROM_____TO_____**		
5. Does the documentation include a valid signature within the designated time frame by the person who delivered the service?		
6. Does the service note(s) relate to goals listed in the PCP?		
7. Does the documentation reflect treatment for the duration of service?		
8. Does the service note reflect assessment of progress toward goals?		
9. Are the service notes individualized per person?		
10. Do the units documented match units paid? **If NO, write units documented: _____**		
QUALIFICATIONS/SUPERVISION/RECORD CHECKS: (Use rating of "4" or "0" for Q 11-15—or ratings of 7, 8 or 9 as applicable)		
11. a. Does the team meet staffing requirements per the service definition? **b. If NO, list dates: FROM_____TO_____**		
12. a. Is there documentation that the staff is qualified to provide the service billed? **b. If NO, list dates: FROM_____TO_____**		
13. a. Is an individualized supervision plan in place for CST, paraprofessional and AP staff? **b. Has the plan been implemented?** **c. If "b" is NO, list dates: FROM:_____ TO:_____**	**a.** **b.**	
14. a. Did the provider agency require disclosure of any criminal conviction by the staff that provided this service? (ACTT and CST) **b. Did the provider agency require the appropriate criminal background check on the staff that provided this service? (PSR)** **c. If NO, list dates: FROM:_____ TO:_____**	**a.** **b.**	
15. a. Did the provider agency complete a Health Care Personnel Registry check prior to this date of service? **b. If NO, list dates: FROM:_____ TO:_____**		

COMMENTS:

AUDITOR:	**LME:**